encountered a significant incidence of deep venous thrombosis (DVT). Our operative times are similar to that of the authors reported experience of about 20 minutes. In addition, these post-Closure DVTs have been found after all eight of our surgeons performed the procedures, all four of the technologists assisted with the intraoperative exam, and all six of the technologists performed the post-Closure scans.

Although the authors report no incidence of edema or pulmonary embolization, the data from FDA website as cited in the text (http://www.fda.gov/medwatch/index.html), suggest that pulmonary embolism and DVT do occur after Closure. Part of this difference may be in how hard one looks for the DVT and the extent of the venous duplex examination. All of our venous duplex examinations routinely examine the calf veins and the muscular veins, along with the femoro-popliteal segment. All of the videos, tapes, and still pictures are reviewed by an attending vascular surgeon. We question the completeness of the postprocedure duplex scan in the series of Dr Goldman et al. Perhaps they concentrated on evaluating the effectiveness of the procedure in the greater saphenous vein rather than looking diligently for associated DVT.

We have not observed any case of pulmonary embolism in our series. Interestingly, we also have not noted much swelling in patients in the patients with DVT. However, one may not have much swelling with a nonocclusive DVT. The documentation of pulmonary embolism after Closure on the FDA website and from other series, would suggest that DVT after Closure should be treated with anticoagulation. Since we have found that these DVTs resolve with low-molecular-weight heparin, we are not placing the filters now but continue to carefully follow the patients with duplex exams.

As we had stated in the discussion, "It is hoped that this issue can be further addressed as more centers report their experience." Since the authors have reported their first 50 patients undergoing the procedure in 2002, a follow-up of these 854 patients would be quite useful. We thank Drs Goldman, Weiss and Gradman for their interest and we encourage them to submit their experience to a peer-reviewed scientific journal.

We obviously remain enthusiastic about the procedure; however, based upon this initial experience and a review of our subsequent experience, we continue to suggest caution.

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Regarding "Dorsalis pedis artery true aneurysm due to atherosclerosis: Case report and literature review"

I read with interest the report by Kato T et al (J Vasc Surg 2004;40:1044-8) describing a dorsalis pedis artery true aneurysm due to atherosclerotic and reviewing the literature on true aneurysms of the infrapopliteal arteries.

In 2002, we reported a combination of bilateral popliteal aneurysm with true bilateral aneurysms of the posterior tibial arteries that had not been previously described,[1] and this article is not cited in Table I of the refered paper.

We completely agree with Dr Kato et al that preoperative or peroperative arteriography or magnetic resonance imaging evaluations of the pedal arch are mandatory. The standard treatment of infrapopliteal aneurysms remains controversial, and ligation with or without excision is the most commonly performed operation. The arteriographic findings are crucial to the success of the surgical approach.

In our patient, the arteriogram demonstrated the absence of both pedal arteries, despite an adequate posterior tibial artery supply to his feet. This persuaded us to interpose a saphenous vein graft after resection of the posterior tibial artery aneurysms to maintain the blood supply to the foot.

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Reply

We appreciate the opportunity to respond to Dr Fernández-Alonso's reflection regarding our article[1] of dorsalis pedis artery true aneurysm and literature review of infrapopliteal true aneurysms. We greatly apologize not to have cited the excellent case report by Fernández-Alonso and Gómez,[2] despite our careful literature research.

In their report, a 60-year-old man without a history of trauma presented with a pulsating and enlarging ankle mass, which has been the most common manifestation of infrapopliteal true aneurysms according to our literature review. They disclosed the absence of the pedal arch by means of arteriography and successfully performed saphenous vein interposition after resection of the posterior tibial artery aneurysms to maintain the blood supply to the feet.

Fernández-Alonso and Gómez correctly pointed out the necessity of arteriography, especially in pedal arch evaluation, which persuades us to resect the aneurysm with or without reconstruction of the affected artery because atherosclerotic aneurysms would often accompany such peripheral arterial occlusive disease. Fortunately, we disclosed the patent pedal arch in our case of dorsalis pedis artery aneurysm by means of preoperative arteriography. Additionally, we measured the stump pressure of the dorsalis pedis artery after resection. The measurement of the stump pressure must be useful in consideration for the reconstruction.

As Fernández-Alonso and Gómez indicated, the surgical indication for infrapopliteal true aneurysms is still controversial. We hope that more experiences will be reported, and have shared our acquaintance with this entity for the benefit of patients who may experience an infrapopliteal true aneurysm.

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